

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>010682</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>08/31/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>BROOKDALE MARION</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2452 W KEM RD</b> <b>MARION, IN 46952</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 000}	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for a Post Survey Revisit (PSR) to the State Residential Licensure Survey completed on July 6, 2016.</p> <p>Survey date: August 31, 2016.</p> <p>Facility number: 010682 Provider number: 010682 AIM number: N/A</p> <p>Census bed type: Residential: 38 Total: 38</p> <p>Residential sample: 7</p> <p>Brookdale Marion was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the State Residential Licensure Survey.</p> <p>QR completed by 11474 on August 31, 2016.</p>	{R 000}		

Indiana State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE